

Active Employee / Retiree / Dependents Group #721059 Dental Benefits Claim Form

Complete this form and submit to: Aetna U.S. Healthcare of Washington P.O. Box 91028 Seattle, WA 98111-9128 1-888-252-2734 -ACTIVE 1-888-252-2732 -RETIREE

- 1	Patient's Name First Init	ial Last			2	Birthda Mo	ate Day Year	8	Is this claim due to an accident or in ☐ Home ☐ Auto ☐ School		Wor		∃Yes	□ No		
3	Relation to Participant							\dashv	Other							
	Self Spouse Child Step Child Other If claim is for dependent child, when charges were incurred, was child: Married?								Date of Accident			do yo				J PM
	Unable to work due to disability?								If accident occured at work is case covered under Workers' Compensati	on?		[∃Yes	□ No		
	Give name and address o	f current or 1	former emplo	yer or school:				9	Do you or any of your dependents hother group medical coverage? (This includes other Aetna U.S. Hea		of W		☐ Yes	□ No		
4	□M □F	-	cial Security I	No. -		-	-		Name and Address of other Carrier_							
6	Participant's Name, Addr	ess, City, St	ate, Zip						Name of Covered Person(s)							
									· · · · · · · · · · · · · · · · · · ·) Nun	nber _					
									Group Num	ber (if	any) _					
7		Is this a New Address? ☐ Yes ☐ No articipant's Telephone No. ()							Coverage is for:	□Sp	ouse	[☐ Chile	dren		
								4. 4								
Par	t 2 / Dental Info			separate	iorm	ior e	eacn der		YY ', 1 /ICYY ', 1' 1)			A 1		D.	D: 1 D	
10			in					13	Hospital (If Hospitalized)			Adr	nission	Date	Discharge Dat	te
10	Dentist Name, Address, O	nty, State, Z	лр						Y		2		·	□ N-		
10	Dentist Name, Address, C	ity, State, Z	лр					14	Is any of this treatment for orthodont Is this treatment for prosthesis?	ic care	?			□ No		
	Dentist Name, Address, C	ity, State, Z		ntist's IRS Ta	x No. or S	Social Se	ecurity No.	14	Is this treatment for prosthesis? Is this initial prosthesis? If no, date of last replacement	ic care	?		es	□ No □ No □ No		
11	Dentist's Telephone No.	ny, state, Z		ntist's IRS Ta: u are required l				14 15	Is this treatment for prosthesis? Is this initial prosthesis?			□ Y □ Y	res res	□ No	ade to the prov	rider.)
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Patient's or Authorized Person's Signature _

This Plan does require predetermination of dental services when total expense exceeds \$500. All predeterminations of benefits are subject to the patient's continuous eligibility for Dental benefits and therefore are not a guarantee of actual benefits to be paid. To receive a predetermination of benefits, check "Dentist's Predetermination Estimate" above, complete this form and send it to us. We will return to you an explanation of benefits. When treatment is completed, check "Dentist's Statement of Actual Services," fill in the dates of service and return it to us for processing. Please submit x-rays.